



COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

January 31, 2013

Dear Members of the Governor's Taskforce on School and Campus Safety:

We are pleased to forward to the full Taskforce the proposals from the Mental Health Workgroup.

The enclosed recommendations reflect a great deal of consideration by workgroup members to present the Taskforce with thoughtful, workable solutions that will improve targeted services and systems to make an even safer Commonwealth for our citizens.

We hope that you will find these proposals helpful. Please do not hesitate to contact us if you have any questions.

Sincerely,

Handwritten signature of William A. Hazel, Jr.

William A. Hazel, Jr., M.D.
Secretary, Health and Human Resources

Handwritten signature of Kenneth T. Cuccinelli, II.

Kenneth T. Cuccinelli, II
Attorney General, Commonwealth of Virginia

Enclosures

**Summary
Mental Health Workgroup Recommendations
January 31, 2013**

Priority Rank	Proposal	Recommended Program Amount
Priority Ranking by Workgroup on January 24, 2013		
1	Suicide Prevention – Expand a comprehensive statewide program of public education, evidence-based training, health and behavioral health (BH) provider capacity-building, and suicide (and related homicide) prevention activities in collaboration with VDH, DOE, DVS, DARS, and other partners. Target audiences will include CSB and private BH providers; health and social service providers; and community gatekeepers including teachers, clergy, law enforcement, youth leaders, military and veteran advocates, and parents and families.	Budget Impact
2	CSB Child/Adolescent Outpatient and Psychiatric Outpatient Services – Expand access to child/adolescent outpatient clinicians and child psychiatrists (direct, consultative, and tele-psychiatry) for behavioral health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance abuse etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem to reduce the likelihood that manageable mental health problems become full-blown crises.	Budget Impact
3	Mental Health First Aid – Five-day instructor training and certification on how to recognize and respond to mental or emotional distress. Some trained instructors will be clinicians who also act as community resource staff for consultations and interventions and will build networks through Virginia 211 referrals. Subsequent 12 hour trainings will target peers, teachers, clergy, health professionals, community agency personnel, military and veteran service organizations and advocates, and other first responders and “gatekeepers” who have extensive public contact.	Budget Impact
4	CIT Law Enforcement Assessment (Drop-off) Centers –Develop new sites for police drop off where an officer can take a person in crisis for access to treatment and quickly return to their regular law enforcement duties. Individuals will receive clinical assessments for possible civil commitment and linkage to services for acute and sub-acute mental health treatment needs 24 hours per day.	Budget Impact
5	CSB Adult Outpatient and Psychiatric Services –	Budget Impact

	Expand access to adult outpatient clinicians and psychiatrists (direct, consultative, and tele-psychiatry) for behavioral health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance abuse etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem to reduce the likelihood that manageable mental health problems become full-blown crises..	
Proposals Ranked Lower than Top Five		
	Transition Services for Young Adults - Outpatient clinicians for youth ages 17 - 25	Budget Impact
	Behavioral Threat Assessment – Multi-disciplinary teams of law enforcement, mental health care, administrative, and education professionals	Budget Impact
	Psychiatry Consultation Project – Psychiatry and Social Work consultation to primary care physicians and others	Budget Impact
	Regional Councils of Stakeholders – to build referral, problem solving and support networks	Budget Impact
	PACT – new Assertive Community Treatment Teams	Budget Impact

Governor's Taskforce on School and Campus Safety 2013 Recommendation Format

Mental Health Workgroup Suicide Prevention

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical to your agency.*

Suicide is a major public health problem. Many of the perpetrators of mass violence, as well as domestic and workplace homicides, are suicidal and many if not most of these events end in the suicide of the perpetrator. Suicide is preventable. Knowledge about suicide and suicide prevention has increased dramatically in the past decade, and evidence-based strategies and interventions are available that can reduce the incidence of suicide.

This proposal is for a comprehensive statewide program of public education, evidence-based training, health and behavioral health provider capacity-building, and related suicide prevention activity in collaboration with DBHDS, VDH, DOE, DVS, DARS, and other partners. The following initiatives are proposed to expand suicide prevention efforts in Virginia.

1) Training and Education: DBHDS will expand its partnership with VDH to conduct suicide prevention training in collaboration with DVS, DARS and DOE. Evidence-based, best-practice programs will include QPR (Question, Persuade, Refer), SafeTALK (Suicide Alertness for Everyone), ASIST (Applied Suicide Intervention Skills Training), and RRSR (Recognizing and Responding to Suicide Risk).¹

Target audiences will include CSB and private behavioral health providers; health and social service providers; and community gatekeepers including teachers, clergy, law enforcement, youth leaders, military and veteran advocates; and parents and families. Education of medical professionals would include the SPRC suicide prevention "tool kit", use of suicide prevention materials in hospital EDs, clinics, etc.

2) Community Capacity-Building: DBHDS will allocate capacity-building grants to CSBs or other local community partners such as medical providers, schools, crisis centers and other community organizations, and to colleges and universities to build and support suicide prevention coalitions; to support needs assessment and strategic planning to reduce suicide; to support public awareness and education; and other suicide prevention activities.

3) State-Level Program Development and Oversight: DBHDS will hire a suicide prevention manager to provide training and technical assistance to communities and stakeholders, state-level strategic planning and policy development, and management and coordination of expanded suicide prevention activity with partner agencies and organizations. The incumbent in this role will be a certified trainer in the suicide prevention interventions described above. The position

¹ These programs are all on the national Suicide Prevention Resource Center's (SPRC) *Best Practice Registry* and offer flexible alternatives to meet specific community needs.

will provide ongoing oversight, management, and documentation of processes, outputs, and outcomes using project management technologies

Background: *Explain the history, including legislative history, behind the issue or problem.*

As has been shown, many recent mass killers were suicidal, but suicide is far more often an individual tragedy. Nationally, suicide is the 11th leading cause of death², while suicide attempts account for hundreds of thousands of emergency room visits and hospital admissions each year. The VDH Office of the Chief Medical Examiner reports both the number of suicides and the suicide rate in Virginia have continued to increase steadily, and Virginia's overall suicide rate is now the highest in 13 years.³ Suicide brings trauma and untold suffering to countless families and friends, yet the stigma associated with suicide masks its true magnitude, and the extent of suicide and related homicide in Virginia is not widely known.

Need: *Explain the problem or issue your agency/stakeholder group is experiencing and how the proposed program will solve the problem. Describe the anticipated results and objectives that your Agency expects to accomplish.*

Virginia's existing, cross-agency suicide prevention effort (with DBHDS, VDH, DVS, DARS, DOE, CSBs and others) offers a strong foundation for a comprehensive suicide prevention program. The current effort, however, is entirely federally funded, and state support is needed to expand it.

This proposal will improve the skills and abilities of service providers and community gatekeepers including teachers, clergy, law enforcement, youth leaders, military and veteran advocates, and parents and families to recognize warning signs and intervene to prevent suicides and, by extension, related homicides.

Measures will be developed and implemented to evaluate the program's efficacy and impact, among which may include the following:

Performance Measures: Number of training events, individuals trained, coalitions developed, conference attendees.

Outcome Measures: Reduction in suicides.

Anticipated Pros and Cons to Implementation of Recommendation(s): *Can you explain counter arguments to the recommendations? What are some of the challenges in implementing the recommendation(s) What groups are likely to support or oppose the recommendations and why?*

Some groups may not readily see the connection between suicidal and homicidal risks and might question the priority of this initiative in the context of school and campus safety. Otherwise, besides the potential cost of the projects, this proposal would likely have widespread support.

Proposed Amendment: *Provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*

² 2007 data from *National Vital Statistics Reports*, V.58, #19, Centers for Disease Control and Prevention

³ *Office of the Chief Medical Examiner's Annual Report, 2011*, Virginia Department of Health, December 2012

N/A

Fiscal Impact: *Does this proposal require financial or personnel resources? Will it generate revenue? Will a Budget Amendment be necessary?*

This initiative is estimated to have an annual cost of between \$650,000 and \$950,000 to implement at the local and regional level and personnel resources to develop and oversee the program. It would not generate revenue and will require a budget amendment.

Governor's Taskforce on School and Campus Safety
2013 Recommendation Format

Mental Health Workgroup
Child and Adolescent Outpatient

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical to your agency.*

The public mental health system is severely limited in its capacity to provide the most fundamental outpatient behavioral health services, namely, timely evaluation and treatment, including medication by a child psychiatrist, for mental health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance use, etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem. This shortage is especially critical in the area of child psychiatry, where the scarcity of child psychiatrists impacts the ability to deliver these services in a timely manner.

The following initiatives are proposed to expand access to outpatient clinicians with specialized experience in children's services and child psychiatrists (direct, consultative, and through tele-psychiatry) in Virginia.

1. **Expansion of Access to Outpatient Services and Capacity at CSBs:** Capacity must be expanded to ensure timely access to care, including to a child psychiatrist for medication, and to reduce the likelihood that manageable behavioral health problems will become full-blown crises. This proposal recommends an expansion of CSB outpatient and child psychiatric services for children as follows:
 - 40 CSBs to be allocated 1 - 2 children's services outpatient clinician FTEs per CSB
 - 5 - 10 FTEs of additional child psychiatry coverage among the CSBs. This may be composed of persons hired or contracts with groups or universities, providing direct, consultative and telepsychiatry services.

2. **State-Level Program Development and Oversight:** DBHDS will hire a Children's Outpatient Services Manager to provide training and technical assistance to communities and stakeholders, state-level strategic planning and policy development, and management and coordination of expanded outpatient activities with CSBs, partner agencies and organizations. The position will provide ongoing oversight, management, and documentation of processes, outputs, and outcomes using project management technologies.

Background: *Explain the history, including legislative history, behind the issue or problem.*

In response to the widely supported recommendations of the Commission on Mental Health Law Reform, the Virginia Tech Review Panel, and the then Inspector General for Behavioral Health and Developmental Services, the Governor and General Assembly made a significant "down payment" in FY 2009 to increase core outpatient evaluation and treatment services capacity at CSBs (\$17.3M in ongoing funding). Unfortunately, the economic downturn almost immediately wiped away all of these gains and more (the ongoing reductions to CSBs totaled \$24M annually). This situation must change in order to improve access to these essential outpatient services. This proposal is virtually

identical in intent to the post-Virginia Tech actions taken by the General Assembly and Governor in 2008, although it is significantly smaller.

Need: *Explain the problem or issue your agency/stakeholder group is experiencing and how the proposed program will solve the problem. Describe the anticipated results and objectives that your Agency expects to accomplish.*

These services are available for insured children in most communities (excepting rural areas), albeit with long waiting periods. In the public sector and for uninsured individuals, however, access to outpatient counseling services is virtually non-existent because behavioral health resources had to be allocated to the most pressing, highest risk needs such as crisis intervention and support of persons with long term disabling mental health conditions. With child psychiatric services, waiting periods are normally longer than those for general psychiatrists. Many children are prescribed psychiatric medications by pediatric and primary care practitioners, who do not have the needed specialized expertise. This well-documented "triage" of scarce resources has left many persons with pressing behavioral health needs without timely access to behavioral health care. Many individuals who are turned away stop seeking help when they need it most, further aggravating the situation.

This initiative will improve timely access to needed behavioral health assessment and counseling services by increasing the number of clinicians and child psychiatrists at CSBs. Measures will be developed and implemented to evaluate the program's efficacy and impact, among which may include the following:

Performance Measures: Number of clinicians and child psychiatrists hired, individuals served.

Outcome Measures: Reduction in waiting times and emergency services needed by the target population.

Anticipated Pros and Cons to Implementation of Recommendation(s): *Can you explain counter arguments to the recommendations? What are some of the challenges in implementing the recommendation(s) What groups are likely to support or oppose the recommendations and why?*

Some groups may not readily see the need for expansion of outpatient services generally, as opposed to school-based services, in the context of school and campus safety. Otherwise, besides the potential cost of the additional staff, this proposal would likely have widespread support.

Proposed Amendment: *Provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*

N/A

Fiscal Impact: *Does this proposal require financial or personnel resources? Will it generate revenue? Will a Budget Amendment be necessary?*

This initiative is estimated to have an annual cost of between \$4,000,000 and \$5,850,000 for additional child outpatient and child psychiatric coverage and personnel resources to develop and oversee the initiative. It would generate an indeterminable amount of revenue from Medicaid eligible children, which would be used to support outpatient and other needed mental health services at the CSB. It will require a budget amendment.

**Governor's Taskforce on School and Campus Safety
2013 Recommendation Format**

**Mental Health Workgroup
Mental Health First Aid**

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical to your agency.*

Mental Health First Aid (MHFA) is a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand and respond to signs of mental illness.

2-1-1 VIRGINIA is a service of the Virginia Department of Social Services that provides an easy to remember phone number connecting people with free information on available community services. When you dial 2-1-1, a trained professional listens to the caller's situation and suggests sources of help using one of the largest databases of health and human services in Virginia. 2-1-1 VIRGINIA provides access to services in the local community and statewide. All referrals are confidential and Virginian's can also search for these same services on this 2-1-1 VIRGINIA Web site (www.211virginia.org).

The following initiatives are proposed to expand Mental Health First Aid efforts in Virginia by conducting MHFA instructor training and certification, adding CSB MHFA instructors and community response clinical navigators and liaisons, expanding Virginia 2-1-1 capacity, and working with first responders.

- 1) **MHFA Instructor Training and Certification Workshops:** DBHDS will implement a "train-the-trainers" model to rapidly spread MHFA around the Commonwealth and will contract with the National Council for Community Behavioral Healthcare to conduct statewide trainer certification workshops. These five day training events yield trainers (from CSBs and private providers) who are capable of doing 12 hour MHFA training events for teachers, clergy, health professionals, EMS volunteers and other first responders, community agency personnel, military and veteran service organizations and advocates, and other "gatekeepers" who have extensive public contact. Among those trained would be behavioral health clinicians assigned to CSBs to not only provide MHFA training but also to be available to community contacts for case consultations, reception of referrals, assessments, and brief interventions on an outreach basis (e.g., at schools, workplaces, or community based agencies). Individuals and family members with real experiences of mental illness will be included as members of the instructor training and community MHFA training sessions.
- 2) **CSB-based MHFA Instructors/Community Response Clinicians:** DBHDS will provide ongoing support for between 25 and 50 (depending on funding levels) behavioral health certified MHFA trainers (trained as described above) to conduct MHFA trainings to teachers and other community gatekeepers and provide ongoing consultation to these and other trained MHFA volunteers, respond to identified concerns, do observations, conduct

assessments, and secure referrals, etc. Having a recognized person for the MHFA-trained volunteers to call and help persons navigate access to outpatient care will greatly facilitate and expedite response to persons with mental health needs.

- 3) **2-1-1 VIRGINIA Referrals and Local Networking:** The MHFA Instructors/Community Response Clinicians described above will work closely with 2-1-1 VIRGINIA to ensure awareness and use by the general public of their training and consultation across the community. The MHFA Instructors/Community Response Clinicians will also develop and sustain a network of trained MHFA community based volunteers to provide ongoing skill development and supports.
- 4) **State-Level Program Development and Oversight:** DBHDS will hire a Mental Health First Aid program manager to provide training and technical assistance to CSBs, communities and stakeholders, state-level strategic planning and policy development, and management and coordination of expanded MHFC and 2-1-1 activities with CSBs, partner agencies and organizations. The position will provide ongoing oversight, management, and documentation of processes, outputs, and outcomes using project management technologies.

Background: *Explain the history, including legislative history, behind the issue or problem.*

The National Council for Community Behavioral Healthcare, the Maryland State Department of Health and Mental Hygiene, and the Missouri Department of Mental Health worked with the program's Australian founders to bring Mental Health First Aid to the U.S. Mental Health First Aid has a strong evidence base. Four detailed studies have been completed and nearly a dozen journal articles published on Mental Health First Aid impact on the public. One trial of 301 randomized participants found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. The study also found that Mental Health First Aid improved the mental health of the participants themselves. Findings from the other studies have echoed these outcomes.

Need: *Explain the problem or issue your agency/stakeholder group is experiencing and how the proposed program will solve the problem. Describe the anticipated results and objectives that your Agency expects to accomplish.*

All too often following mass violence events and personal tragedies such as suicides and domestic or workplace shootings, it is said that the killers seemed to show some warning signs, sometimes even asking for help. Some of this violence is preventable if persons are alert to the signs and symptoms of mental illness or risks of suicide and other violence.

This proposal will improve the skills and abilities of community gatekeepers including teachers, clergy, law enforcement, youth leaders, military and veteran advocates, and parents and families to recognize signs of distress and intervene to offer appropriate help before an individual's problems become more critical.

Measures will be developed and implemented to evaluate the program's efficacy and impact, among which may include the following:

Performance Measures: Number of training events, trainers trained, individuals trained, 2-1-1 referrals, volunteers in network, individuals served by clinicians.

Outcome Measures: Improved outreach and advisement.

Anticipated Pros and Cons to Implementation of Recommendation(s): *Can you explain counter arguments to the recommendations? What are some of the challenges in implementing the recommendation(s) What groups are likely to support or oppose the recommendations and why?*

Some consumer advocates have expressed concerns that people completing this training would think they now have the knowledge needed to “guess diagnose” someone, resulting in labeling and negative self-fulfilling prophecies. Unfortunately, the program has sometimes been introduced as something that teaches people how to “spot” mental illness, or those who may be “unstable.” But in fact, this is the kind of language and perspective that the course tries to combat and the proposed instructors will need to create respectful “teachable moments” with participants who may come with more stigmatizing perspectives. Including in the training sessions individuals and family members with lived experience of mental illness will provide for effective and powerful first-person accounts of what worked well for them. Besides these concerns and the potential cost of the projects, this program enjoys wide support nationwide.

Proposed Amendment: *Provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*

N/A

Fiscal Impact: *Does this proposal require financial or personnel resources? Will it generate revenue? Will a Budget Amendment be necessary?*

This initiative is estimated to have an annual cost of between \$2,220,000 and \$5,850,000 to implement at the local and regional level and personnel resources to develop and oversee the program. It would not generate revenue and will require a budget amendment.

Governor's Taskforce on School and Campus Safety
2013 Recommendation Format

Mental Health Workgroup
Adult Outpatient Services

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical to your agency.*

The public mental health system is severely limited in its capacity to provide the most fundamental outpatient behavioral health services, namely, timely evaluation and treatment, including medication by a psychiatrist, for mental health conditions such as depression, anxiety, disturbing thoughts, interpersonal or relationship problems, substance use, etc., in a one-to-one, counselor-client setting, as early as possible to the onset of the problem.

The following initiatives are proposed to expand access to adult outpatient clinicians and psychiatrists (direct, consultative, and through tele-psychiatry) in Virginia.

1. **Expansion of Access to Outpatient services and capacity at CSBs:** Capacity must be expanded to ensure timely access to care, including to a psychiatrist for medication, and to reduce the likelihood that manageable behavioral health problems will become full-blown crises. This proposal recommends an expansion of CSB outpatient and psychiatric services for adults as follows:
 - 40 CSBs to be allocated 1 - 2 outpatient clinician FTEs per CSB, depending on funding level
 - 5 - 10 FTEs of additional psychiatric coverage among the CSBs, depending on funding level
2. **State-Level Program Development and Oversight:** DBHDS will hire an Outpatient Services Manager to provide training and technical assistance to communities and stakeholders, state-level strategic planning and policy development, and management and coordination of expanded outpatient activities with CSBs, partner agencies and organizations. The position will provide ongoing oversight, management, and documentation of processes, outputs, and outcomes using project management technologies.

Background: *Explain the history, including legislative history, behind the issue or problem.*

In response to the widely supported recommendations of the Commission on Mental Health Law Reform, the Virginia Tech Review Panel, and the then Inspector General for Behavioral Health and Developmental Services, the Governor and General Assembly made a significant "down payment" in FY 2009 to increase core outpatient evaluation and treatment services capacity at CSBs (\$17.3M in ongoing funding). Unfortunately, the economic downturn almost immediately wiped away all of these gains and more (the ongoing reductions to CSBs totaled \$24M annually). This situation must change in order to improve access to these important outpatient services. This proposal is virtually identical in intent to the post-Virginia Tech actions taken by the General Assembly and Governor in 2008, although it is significantly smaller.

Need: *Explain the problem or issue your agency/stakeholder group is experiencing and how the proposed program will solve the problem. Describe the anticipated results and objectives that your Agency expects to accomplish.*

Insured adults can usually find these services in most communities, albeit with long waiting periods. In the public sector and for uninsured individuals, however, access to outpatient counseling services is virtually non-existent because behavioral health resources have had to be allocated to the most pressing, highest risk needs such as crisis intervention and support of persons with long term disabling mental health conditions. With psychiatric services, waiting periods are normally eight weeks or more. This well-documented “triage” of scarce resources has left many persons with pressing mental health needs without timely access to mental health care. Many individuals who are turned away stop seeking help when they need it most, further aggravating the situation.

This initiative will improve timely access to needed behavioral health assessment and counseling services by increasing the number of clinicians and psychiatrists at CSBs. Measures will be developed and implemented to evaluate the program’s efficacy and impact, among which may include the following:

Performance Measures: Number of clinicians and psychiatrists hired, individuals served.
Outcome Measures: Reduction in waiting times and emergency services needed by the target population.

Anticipated Pros and Cons to Implementation of Recommendation(s): *Can you explain counter arguments to the recommendations? What are some of the challenges in implementing the recommendation(s) What groups are likely to support or oppose the recommendations and why?*

Some groups may not readily see the need for expansion of outpatient services generally, as opposed to school-based services, in the context of school and campus safety. Otherwise, besides the potential cost of the additional staff, this proposal would likely have widespread support.

Proposed Amendment: *Provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language.*
N/A

Fiscal Impact: *Does this proposal require financial or personnel resources? Will it generate revenue? Will a Budget Amendment be necessary?*

This initiative is estimated to have an annual cost of between \$4,000,000 and \$5,850,000 for additional outpatient and psychiatric coverage and personnel resources to develop and oversee the initiative. It would generate an indeterminable amount of revenue from Medicaid eligible individuals, which would be used to support outpatient and other needed mental health services at the CSB. It will require a budget amendment.

Governor's Taskforce on School and Campus Safety 2013 Recommendation Format

Mental Health Workgroup CIT Assessment Centers

Summary: *Explain the legal, program and policy changes proposed. Describe actions involved and elaborate why the proposal is critical to your agency.*

Law enforcement first responders are often the first contact for persons with mental illness when they are in crisis. Law enforcement is, by Code, in contact with every individual held under an Emergency Custody Order (ECO). Until the advent of Crisis Intervention Teams (CIT), law enforcement did not receive sufficient training in the unique response skills needed to effectively respond in the field to persons in mental health crisis. As a result, unaddressed escalating behaviors increased the likelihood of injuries to law enforcement, the person in crisis and by-standers. It also increased the likelihood of arrest and incarceration because law enforcement was often unfamiliar with availability of and access to treatment in their local community as an alternative to arrest. Additionally, traditional law enforcement command and control training, while effective in most situations, often had the opposite effect on individuals in crisis, escalating behavior to the point where arrest became unavoidable. Once a law enforcement officer became involved in an ECO, the process of assessment and determining whether a Temporary Detention Order was necessary and the time involved in locating an appropriate hospital bed for the individual could keep law enforcement from their regular duties for as much as 10 to 12 hours.

A CIT Drop Off site is the key component for a successful CIT program. It is a physical location (herein referred to as an Assessment Site), which is not a jail, lock-up or other criminal justice venue. Utilization of an Assessment Site facilitates law enforcement's ability to provide a person in crisis with ready access to treatment and to quickly return to their regular law enforcement duties. Assessment Sites are a therapeutic, non-criminal justice affiliated alternative to incarceration, reducing officer involved time, lowering the rate of arrest and incarceration, and reducing trauma and stigma for the person in crisis. Located in hospital Emergency Departments, Crisis Stabilization Units or other clinical facilities, these sites are available and accessible for a law enforcement custodial hand off, clinical assessment for possible civil commitment, and for referrals and linkage to services for acute and sub-acute mental health treatment needs *24 hours per day*, compatible with the statutory and policy goals of Virginia's CIT programs (see sections 9.1-102, 9.1-187, 9.1-188, 9.1-189 and 190, *Code of Virginia (1950), as amended*).

Proposed CIT Assessment Site Enhancement and New Site Funding

The following programmatic changes are proposed to expand capacity and efficacy of existing Crisis Intervention Team Programs in Virginia.

1. **Develop Three (3) to Five (5) Additional CIT Assessment Sites:** Identify 'shovel ready' sites and fund personnel to support 24/7 operation of 3 – 5 new Assessment Sites.
2. **Enhance Three (3) Existing CIT Assessment Sites to Achieve 24/7 Capacity:** Improve newly funded and operational CIT Program Assessment Sites in Henrico, New River Valley, and Portsmouth/Chesapeake by adding 2.0 FTE additional Security and 1.0 FTE additional Clinician at each site.

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3. **State-Level Program Development and Oversight:** DBHDS requests 1.0 FTE for a CIT Program Manager to provide training and technical assistance to communities and stakeholders, state-level strategic planning and policy development, and management and coordination of expanded youth transition activities with CSBs, partner agencies and organizations. The position will provide ongoing oversight, management, and documentation of processes, outputs, and outcomes using project management technologies.

Background: *Explain the history, including legislative history, behind the issue or problem.*

At its core, CIT provides 1) 40 hours of law enforcement crisis intervention training to enhance police response to individuals exhibiting signs of a mental illness; 2) leadership to promote effective local systems change and problem solving regarding interaction between the criminal justice and mental health care systems; and, 3) improved community-based solutions to enhance access to services for individuals with mental illness, with the provision of an Assessment Site representing the key access point in the CIT Model.

Virginia began developing CIT in 2001 when the New River Valley CIT program partnered with the Memphis Police Department and CIT program creators Maj. Sam Cochran (ret.) and Dr. Randy DuPont of the University of Memphis. That partnership resulted in the nation's first rural, multi-jurisdictional CIT program, located in the New River Valley and incorporating 15 law enforcement agencies, the local Community Services Board, private providers and consumers. In 2005, DCJS secured a General Fund allocation that enabled New River Valley to assist other communities in the development of CIT programs. Byrne grant funding for CIT became available in 2006 and DBHDS and DCJS worked collaboratively with localities to provide technical assistance, especially focused on providing training and the establishment of procedures and policies which would stand in for the development of Assessment Sites – meeting some, but not all of the goals for CIT – until funding for Assessment Sites could be made available.

As of August 2012, 4,337 individuals have completed a 40-hour CIT Training. Of that total, 3,758 were Police, Sheriffs Deputies, or Jail Corrections Officers, 333 were Other First Responders (EMS, Fire, Rescue), and 246 were Mental Health professionals. Now Virginia has 30 CIT Programs are active in 101 of Virginia's 134 localities - 75% of the state; 83% of Virginia's total population lives in an area with a CIT Program initiative underway. CIT programs are classified as Operational (9), Developing (12) or Planning (9).

Need: *Explain the problem or issue your agency/stakeholder group is experiencing and how the proposed legislation will solve the problem. Describe the anticipated results and objectives that your Agency expects to accomplish.*

Effective CIT Programs are best seen as a three legged stool. A fully operational CIT program 1) provides incomparable mental health response training for law enforcement, 2) creates local, collaborative leadership between criminal justice and behavioral health partners to establish and oversee necessary policy, procedure and program modifications, and 3) provides for improved access to services utilizing a CIT Assessment Site.

A fully operational program has the greatest efficacy in improving officer and consumer safety, reducing inappropriate incarceration and redirecting individuals with mental illness from the

criminal justice system to the health care system when to do so is consistent with the needs of public safety.

Currently, there are 11 CIT Assessment Sites in Virginia. None are funded to provide fully accessible 24/7 care options. Three were recently funded at approximately \$200,000 each per annum. In Henrico County, the program operates with limited hours and still saw 56 crisis intakes within the first month. Data being collected by the three new initiatives includes officer involved time on CIT calls, injury rates, clinical and criminal justice disposition.

The development and support of CIT Assessment sites is the final critical component to the success of CIT programs in Virginia. In locations with CIT Assessment sites, local data demonstrates the substantial decrease in arrest and injuries a fully operational program can yield (see attachment, Thomas Jefferson Area CIT Program Report, FY 2009 – 2012). Without this critical linkage to services, even the best CIT program cannot effectively achieve the goals set forth by Code for CIT Programs in Virginia.

Anticipated Pros and Cons to Implementation of Recommendation(s): *Can you explain counter arguments to the recommendations? What are some of the challenges in implementing the recommendation(s) What groups are likely to support or oppose the recommendations and why?*

With the exception of cost, there is little in the way of policy or constituent group opposition to the development of these programs. Reducing injury, reducing inappropriate arrest and incarceration of individuals with mental illness, reducing officer involved time, putting law enforcement quickly back to work in their primary patrol functions, reducing stigma and improving access to services benefit the criminal justice system, the behavioral health system and the lives of those with mental health conditions.

Challenges include developing local partnerships that permit the use of existing clinical sites to be utilized as CIT Assessment Sites, identifying, hiring and training security and clinical personnel and establishing consistent reporting standards and program oversight.

Proposed Amendment: *Provide a draft of the proposed changes to the Code of Virginia in the legislative bill format. Strike through language to be deleted and underline new language. N/A*

Fiscal Impact: *Does this proposal require financial or personnel resources? Will it generate revenue? Will a Budget Amendment be necessary?*

This proposal requires financial and personnel resources. Each operational Assessment Site will require security/law enforcement personnel for custodial hand off and on site emergency services clinicians. Modest initial site security modifications, computer and other IT infrastructure and additional local administrative personnel should also be anticipated, but may be available through existing local resources.

Additionally, DBHDS, due to increase in program growth, will require 1.0 FTE to oversee program implementation and provide ongoing technical assistance, data collection and outcome analysis.

While not generating revenue, local CIT programs have seen reductions in the cost of incarceration (reduced jail bed days), reduced cost of treatment (increased voluntary commitment and increased resolution of mental health crisis in the field). See TJA report.

A budget amendment will be necessary.

\$ 1,050,000 for three new CIT Assessment Sites and a half time statewide Program Manager position ranging to \$1,900,000 for 5 new CIT Assessment Sites, enhanced funding for 3 existing assessment sites and a full time Program Manager position.